Global Conference on Health Promotion (6GCHP)
7-11 August 2005 Bangkok, Thailand

POLICY AND PARTNERSHIP FOR ACTION : THAILAND CONTEXT

TECHNICAL PAPERS

ISBN : 974-506-491-2

World Health Organization

Ministry of Public Health, Thailand

6th Global Conference on Health Promotion (6GCHP)

7-11 August 2005 Bangkok, Thailand

POLICY AND PARTNERSHIP FOR ACTION : THAILAND CONTEXT

TECHNICAL PAPERS

ISBN : 974-506-491-2

HPE-100

POS

CONTENTS

PREFACE

As joint organizer of the 6th Global Conference on Health Promotion, the Thai Ministry of Public Health is pleased to provide participants with this booklet, which contains summaries of the 11 papers to be presented on Wednesday, 10 August 2005, or "Thai Day". The theme of that Day is "Policy and Partnership for Action : Thailand Context".

The technical papers analyse and synthesize various issues related to health promotion in Thailand over the past half century.

We hope that participants will find these success stories interesting and that they will provide useful examples of the development and implementation of their health promotion programmes undertaken in partnership with others, including United Nation agencies especially the World Health Organization, generous foreign governments and various non-governmental organizations.

Ministry of Public Health
August, 2005

Move for Health : From Policy to Action

Tienthavorn V.
Permament Secretary of Public Health

The World Health Organization (WHO) estimates that overall physical inactivity causes 1.9 million deaths globally. Thailand will be in the same circumstance very rapidly if there is no measure to solve the problem. Each year Thailand loses 250,000 million baht in medical treatment and 350,000 people die. Health condition of Thai people tends to change from communicable to non-communicable diseases such as cardiovascular disease, cancers and accidents.

Transition of Physical Activity in Thailand

In the past, physical activities were not visible because they were aligned with people's occupations or ways of life, which mostly involved agriculture. Exercise and sports were strongly promoted from 1964 following the establishment of "The Sports Organization of Thailand" under Dr. Udom Posakrisna and his colleagues use and become "Sports Authority of Thailand" in 1985.

Awareness of exercise for health became widespread after Dr. Udomsil Srisangnam had disseminated his article about running for health. However, preference of exercises were in only some groups until the government under the premiership of Prime Minister Thaksin Shinawatra and Minister Sudarat Keyuraphana declared the year 2002 as a year to initial a nationwide campaign for health promotion under the national strategy of "empowerment for health". In addition, the Prime Minister also declared that the period 2002-2004 would be dedicated to a nationwide health promotion campaign by the cooperation from other related public and private sectors.

The cabinet passed a resolution declaring the 27th of November each year, which also coincided with the day commemorating the foundation of the Ministry of Public Health (MoPH), as the National Day of Health Promotion. After that, special events were organized each year since 2002.

Implementations

Responding to the government's policies, Ministry of Public Health has implemented the following activities to reach for the targets :

1. Policy Declaration
   An important initial step in promoting the building of health was a declaration of policy and targets of the nationwide campaign for health promotion which declared the year 2002 as a starting point and a strong effort to push for the cabinet announcement to adopt 27th November of each year as the national day for health promotion.

2. The First National Power of Exercise Day. The MoPH organized a big event during 22-24 November 2002 to celebrate the first National Day of Health Promotion to add greater and move memorable touch to the event previously celebrated only as the founding of the ministry. The event drew out a record of 46,824 people from Bangkok vicinity provinces and to do the aerobic dance with the Prime Minister as a leader. It was subsequently accepted as a new world record for the most people exercising at the same time; it is documented in the Guinness Book of Records.

3. Building Health by Thai Style and Drug Safe Project. This project was conducted to follow the First National Power of Exercise Day and extend it to grass root levels : regions and provinces. People would be aroused to de exercise by international or Thai styles and the MoPH allocated funds as rewards or incentives.

4. Organization of the 2nd National Power of Exercise Day. The second year event of the mass campaign for physical activity and

exercise was once again highly successful. A total of 76,986 people turned up to participate in exercise and visit the exhibition where as many as 8,584,103 people joined the event in their respective areas of residence, making a total of 8,661,089 people who participated in the second year event in the entire Kingdom of Thailand.

5. Organization of the 3rd National Power of Exercise Day. When the time came for the organization of the 3rd National Power of Exercise Day scheduled for 23 November 2004, the target was set much greater to attract up to 33 million people to join the exercise movement in response to the Prime Minister's address at the opening of the second year event. It was also to be organized with additional auspicious purpose of honoring and commemorating His majesty the King's Birthday celebration on December 5 and Her Majesty the Queen's 72 Birthday on August 12. The event was officially named "A Yellow and Blue Day Mass Campaign in Honor of Their Majesties the King and Queen's Birthdays". Most importantly, Princess Ubolrattana, the eldest daughter of their Majesties, graciously presided over the opening of the event and later participated in the aerobic dance. In Bangkok itself, started from 5 a.m. until 5 p.m., 77,868 people registered at the Sanam Luang aerobic dance and 212,232 people did so at the sports grounds and public parks all over the Greater Bangkok Metropolis. Adding another 42,820,543 from 75 provinces of the country, a record of 43,110,643 people registered for the event's exercise, the number was far greater than the target of 33 million.

6. Exercise for health public relations. The public relations plan named "Move with Doe-Re-Me" was organized to help the Thai people realize the importance of exercise and transfer the important context of exercise for health to be considered and practised. The message "exercise at least 3 days a week, 30 minutes a day" is used

because it is easy to understand and remember.

7. "30" Relay Running Race Project. This activity was for school children who would set 30 children as a team to join running race in order to exercise, play sport together and work as a team. The MoPH also allocated funds as their rewards and 25% of schools joined this activity.

8. Visit Health Promotion Workplaces Project. Although there are no rules about welfare, some workplaces provide welfare to their employees according to the standard level of the company especially in exercise promotion which can be done voluntarily. The Minister of Public Health visited 14 workplaces where there were supporting policies for exercising in workplaces. Those workplaces also received Prime Minister Awards for their strong policy.

9. Honorary Health Cards in "Move for Health Project". This card is like a reward given to the one who joins "Physical Activity Accounts Program" completely. It is a discount card which can be used in the shops which have agreement with the MoPH.

10. Public Health Meet People Project. In a big city like Bangkok, there are many places where people can join together like department stores or parks. Public relations in these areas will easily help people have knowledge about physical activity.

11. Health Promotion/Exercise Clubs : a strong formation to create a sustainable around war for physical activities. Its objectives are gathering people to join into groups and exercise together as health promotion or exercise clubs which can take a leading role in promoting exercise for health to other people in communities. The MoPH also supports budgets and exercise equipments to these clubs.

12. Training Courses. The MoPH, in cooperation with universities, held training courses for the leaders of exercising groups such

as aerobic dance, Yoga, Tai Chi, etc., in order that they could have knowledge to transfer to the others who could not attend courses.

Results

As a result of the comprehensive implementation measures on health promotion by the Ministry of Public Health, pictures of groups of people gathering for exercise are commonly seen everywhere throughout the country. From the national survey on exercise behavior, it was found that people who exercised completely 3 days a week and 30 minutes a day in 2003 were 16.7% and increased to 24.3 in 2004. However, from physical activity surveys, the results showed that total physical activity rates in Thai people were increased as shown in the following table:

Data	Prior to the Policy (before 23 Nov. 2002)	August 2003 Achievement	Increase Achievement	August 2004 Achievement	Increase Achievement
1. No. of people >6 yrs. engage in physical activity	11,538,981 (20.2%)	27,075,000 (46.6%)	15,536,018	43,902,251 (78.3%)	16,827,251
2. Health promotion clubs	10,638	35,184	24,546	58,770	23,586

In addition, health promotion clubs has increased the numbers from 10,638 (before 2002) to 58,770 in August 2004 and 75,018 in December 2004.

Lessons Learned

After 3 years of in implementation the MoPH has learned a lot of experiences and necessary strategies which could lead to its success :

1. **Policy Commitment and Leadership.** The success of national exercise for health promotion came from the governments awareness and

ranking of this as one of the top priorities of policy. Besides, the strong leadership of Minister and high ranking officers of the MoPH both in participating in activities and motivating were also supportive factors to this success.

2. **Social Marketing.** Most activities used a measure of social marketing by working through public relations, campaigns (by settings) and age groups as well as setting events at Sanam Luang and down to regional and provincial levels every year until yellow t-shirt became a symbol of exercises.

3. **Implementation through people in communities.** Increasing the mass to join exercise activities in the form of "Health Promotion or Exercise for Health Clubs" is considered important way to promote people's awareness of exercise and will accept it as their habit or health behavior.

4. **Measures for all target groups.** Since there are different kinds of exercise suitable for each group, i.e., age, sex, occupation, etc., the MoPH has plans/projects for physical activity and health covering all target groups. There are alternatives for motivation and models which are seriously and widely implemented to produce effective outcomes.

5. **Financial and Technical Support.** The government allocated special funds to the MoPH for public relations campaigns or activities. Thus, the MoPH supported budgets and equipments to health promotion clubs' activities as well as training them of their exercise knowledge and skills.

6. **Creation of Motivation.** Measure of motivation has been used very much such as providing rewards to any regions or provinces which had the most number of people joining the National Power of Exercise Day, the best schools and workplaces in "30" Relay Running Race, signboards and honorary cards to health promotion clubs and honorary cards for people who joined

"Physical Activity Accounts' programme completely.

7. **Creation of Supportive Environment.** The MoPH has aroused and suggested local government organizations to provide or improve public parks, places where people could exercise comfortably and safely.

Suggestions

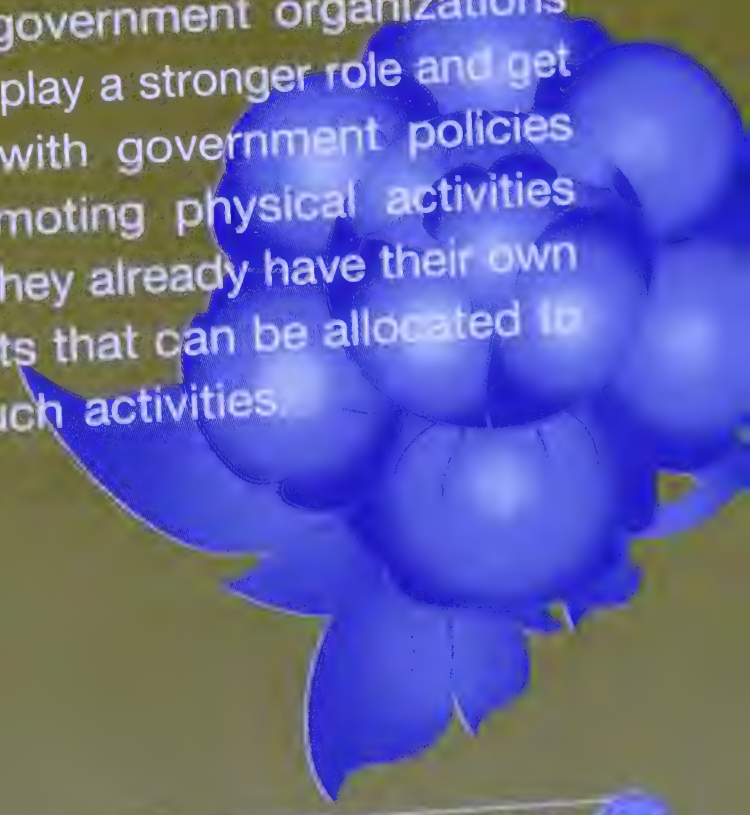
1. **Policy Advocacy at the Global and National Levels**
   The World Health Organization as a policy advocator should continue to play this important role and stimulate the Member States to realize the importance of physical activity and diet through health promotion public policy.

2. **Enlarging Social and Physical Environment**
   People must have opportunities to access places to exercise safely near their homes or workplaces including sidewalks and bike lanes.

3. **Various Alternatives**
   Although people realize the benefits of exercise and have a variety of exercise patterns, there are many of them still have sedentary lifestyle. Thus, their ways of life should be considered particularly in order to promote their daily physical activities to be appropriated to their health.

4. **Research and Development**
   People seem to have incorporated physical activities into their daily lives. This is an advantage for doing more research about informal physical activities and health and the differences of expenditures on medical services.

5. **Local Policy**
   Local government organizations should play a stronger role and get along with government policies in promoting physical activities since they already have their own budgets that can be allocated to any such activities.



FOOD SAFETY PROGRAMME: A KEY COMPONENT HEALTH PROMOTION

Pothisiri P.
Srithamma S., Vithayarungruangsri J. and Posayanonda T.

Effective national food control systems are not only essential to protect the health and safety of domestic consumers, but they are also critical in enabling countries to assure the safety and quality of their food entering the international trade system, as well as to ensure that the standards for imported foods conform to national requirements.

Based on guidelines from the Food and Agriculture Organization of the United Nations (FAO) and the World Health Organization (WHO), essential elements that should be addressed in national food safety strategies include the following:

- Collection of baseline information
- Scientific risk assessment: basing decisions on the best available scientific evidence
- An integrated "from-farm-to-table" approach
- Legislation and law enforcement for a strict food safety control system
- Consumers playing a role and industries being involved
- Performance indicators
- Strategic planning (including official control requirements)

In addition, regarding the Millennium Development Goals mentioned in the Draft Bangkok Charter for Health Promotion that may be adopted on 11 August 2005, an effective new approach to health promotion is

called for and the participation of all related sectors - government, industry and community at different levels is required.

Thai food is now very well-known and famous throughout the world. Thailand is considered one of the "breadbaskets of the world", a land where food and agricultural products are plentiful. Thailand is globally recognized as a leading producer and exporter of food and agricultural products. Large quantities of processed food and agricultural products are exported from Thailand to supply the dietary needs of many countries around the world. Therefore, the development of a national food safety strategy is needed, based on situational analysis, to strengthen and integrate the entire food control system to achieve the best possible protection of consumer health, prevention of fraud and deception, avoidance of food adulteration and facilitation of trade and economic growth.

The Thai government declared the year 2004 as "Thailand's Food Safety Year". Food safety policy was pursued and an action plan was comprehensively implemented by all related sectors at both the central and provincial levels for the promotion of food safety and nutritious food.

The two main ministries responsible for food safety control in Thailand are the Ministry of Public Health and the Ministry of Agriculture and Cooperatives. The Minister of Public Health is designated by law to be in charge of the execution of the 1979 Food Act, and is empowered to appoint competent officers, promulgate regulations and set other activities in order to carry out the provisions of this Act. At the farm level, the system is controlled by the Ministry of Agriculture and Cooperatives. However, food control activities are also undertaken by other related organizations in other ministries, such as the Ministry of Interior and Bangkok Metropolitan Administration.

A Cabinet resolution on 4 March 2004 approved the "Road Map of Food Safety" as a framework for

the control of food and agricultural products at the operational level throughout the food chain. The framework clarifies distinct roles and responsibilities of each food-control organization in Thailand in order to reduce duplication of effort and overlapping actions among food-control authorities. Therefore, a more effective food safety control system has been established to achieve the best possible level of health protection for consumers.

The National Food Safety Programme, implemented under Thailand's Food Safety Policy, is aimed at assuring the safety of food available in Thailand, and assuring that the standards of food available in the country and food exported are comparable to or comply with international standards. Five strategies implemented in the National Food Safety Programme include the following: (1) development of regulatory measures to comply with international food standards; (2) strengthening of food safety monitoring and risk-management systems; (3) empowerment of consumers; (4) capacity-building and information-networking; and (5) development of laboratory capability.

A number of outcomes have been reported consequent to the implementation of the National Food Safety Programme:

1. Closer collaboration and participation on food safety issue of all related parties, including the governmental sector, food industries, farmers, the media, educational institutes and communities.

2. Thailand was selected as the host country for the Second FAO/WHO Global Forum for Food Safety Regulators (GF-2), which was a major international conference on food safety held from 12 to 14 October 2004 at the United Nations Conference Centre in Bangkok. Hundreds of delegates from 90 countries and 11 international organizations, as well as 70 observers

from governmental and non-governmental organizations participated in this conference. The conference was aimed at strengthening capacity-building and increasing the effectiveness of the food safety control system in every country concerned in order to reduce international trade barriers caused by food safety concerns. In addition, the conference was considered as an important impetus for all countries to be concerned about the importance of increasing food safety standards in their own countries. Further, this conference created a good image for Thailand, in particular concerning food safety awareness reflecting the concerns of the Thai government and consumers, and has resulted in an increase in the export of Thai food and agricultural products in addition to helping boost tourism in the country.

3. Thailand has been accepted by the members of the Association of South East Asian Nations (ASEAN) and assigned by the ASEAN Committee on Food Safety to be the centre for the ASEAN Food Safety Network. The ASEAN Food Safety Network Website has been successfully established, serving as a platform for exchanging information between and among member countries. The exchanged information is related to non-tariff barriers on the international trade in food, agricultural and fishery products, conformity with food standards, laws and regulations, as well as in seeking a common position for ASEAN. Regarding the success of this Network, Thailand has gained remarkable recognition regionally and internationally. Also, consumer confidence in Thai food, agricultural products and industries has been elevated (National Bureau of Agricultural Commodity and Food Standards (ACFS). Annual Report 2004).

4. Thailand's domestic food standards will be harmonized, and those standards will be in compliance with international standards. The proportion of food and agricultural products exported from Thailand to international markets that has been detained or rejected significantly decreased since Thailand's Food Safety Programme has been implemented (see Tables 1-4).

The most important factors in the success of the National Food Safety Programme are the following: (1) Her Majesty the Queen's strong support for many food safety projects; (2) the driving force of the Prime Minister and the Cabinet through authorizing agencies, focusing on regular food safety monitoring throughout the entire food chain; (3) the incorporation of risk-analysis principles into the food safety control strategies of all the sectors involved; (4) implementation of strict and regular surveillance and monitoring of food contaminants by the Ministry of Public Health; (5) an increase in society's concern about food safety; and (6) the involvement of the private sector in the food safety control system.

However, an effective food safety control system should be sustainable and continuously developed. Therefore, the following plans are needed for further improvement and development of a more effective and better food safety control system in Thailand:

1. The Food Safety Programme will be extended to focus more on high-risk foods and the risk-analysis principle will be the main approach used in this regard.

2. Traceability will be applied completely across the entire food chain in the national food safety control system.

3. All related parties will participate more effectively in the food safety control system. The young generation and school children will also learn more about the importance of

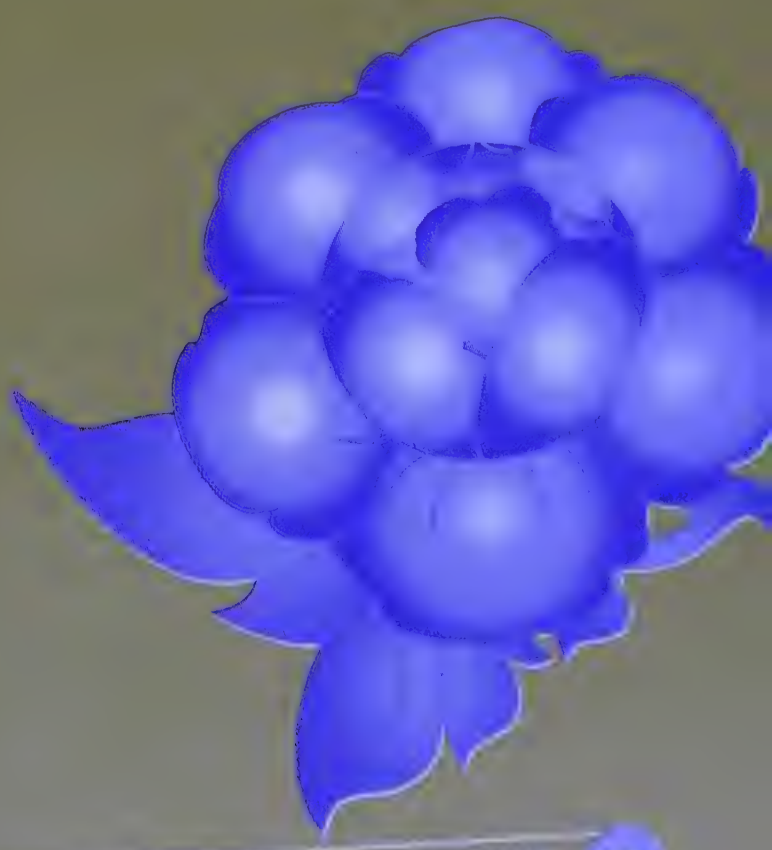
food safety and nutrition via the new education programme, which includes food safety, nutrition and food security issues within the curriculum.

4. The importance of all safe-food logos and emblems will be continuously emphasized to enable the public to choose and purchase safer food.

5. To make the "Q" logo on agricultural products better known in both domestic and international markets, more focus will be given to the logo when it is introduced to the public.

6. Organic farming will be more focused and introduced nationwide.

7. The Thai government will support the domestic production of test kits used in testing for food contaminants. Therefore, test kits will be made more affordable and accessible for consumers.



Environmental Health: The Challenge for Health Promotion

Charoensak S., Punpeng T., Department of Health, MoPH

Rapid globalization has resulted in worldwide movements to prevent negative consequences. It also emphasizes the need to address issues related to socio-economic development, environment and health. There are linkages among socio-economic development, environment and health; therefore, in order to cope with the existing double burden, issues related to socio-economic development, environment and health need to be addressed together in a comprehensive manner.

With respect to health promotion, the health sector is being challenged to assume new roles as leader and advisor to other sectors, thus promoting strong intersectoral actions for health. Environmental health has clear linkages among socio-economic development, environment and health. Policy decision makers and the public policy process with regard to the reduction of environmental health risks are challenges in health promotion with respect to the creation of policies for a healthy public and a healthy environment.

Part I. Evolutionary view of environmental health in Thailand

Coping with basic sanitation problems in early development

Early environmental health development mainly involved the provision of basic sanitation such as the disposal of waste and human excreta, and the supply of clean water together with other measures to cope with existing traditional health hazards. There were clear boundaries to the roles and responsibilities of the governmental organizations involved. The Ministry

of Public Health was the principal responsible organization. The government was the "provider" and the people were the "receivers".

Introduction of primary health-care concept: Community participation in early environmental health programmes

There has been more interministerial cooperation since the time of the Fifth National Economic and Social Development Plan, and the government began to use a strategy for community participation, community strengthening and personal skill development.

Policy approach to cope with environmental problems led by industrialization and modernization

Thailand enacted the Enhancement and Conservation of National Environmental Quality Act in 1975. The National Environmental Board, chaired by the Prime Minister, was the governmental body in charge of environmental administration of the country by means of enforcing the Enhancement and Conservation of National Environmental Quality Act.

The Environmental Programme for Health Protection became the Environmental Health Programme in the five-year National Economic and Social Development Plans

In the Seventh National Economic and Social Development Plan the country faced both traditional hazards and modern hazards as a result of rapid industrialization. Basic sanitation alone was not able to cope with the existing problems; thus, environmental health took its place together with basic sanitation.

Environmental health management legislation

In order to cope with the rapid changes in the country's context both internally and externally, and to facilitate more efficient law enforcement, a reformation of health and environmental management laws and regulations took place in 1992. Important laws included the Industrial Act, the Public Health Act, the Toxic Substance Act and the

Enhancement and Conservation of Environmental Quality Act.

The new constitution: People become the centre of comprehensive development

The Constitution of the Kingdom of Thailand, B.E. 2540, was promulgated in 1997. The constitution assures civil rights in the Basic National Policy, which provides guidelines for public administration and decentralization of the State authority from the central government to local governments. The local governments are empowered for autonomy, including making local policy decisions, taking care of local public administration and management, overseeing local budgeting and financing, and providing public health services. As a result of the new constitution, the Eighth National Economic and Social Development Plan reflected a shift in development concept, from one highlighting economics to one focusing on people, or the human dimension - in other words a people-centred approach. "Healthy cities" was also set as an important strategy for national development.

Health system reform: Holistic health

In 2000 there was a movement within the country towards health system reform, and the adoption of a new law on health based upon the contemporary "new public health paradigm" that put more emphasis on "building health" than on "repairing health". The National Health System Reform Committee has submitted the relevant draft legislation, but until now it has still not been passed into law. An important mechanism that the law would possess would be the establishment of a National Health Assembly, which would act as a national platform for governmental organizations, the general public and other stakeholders to participate actively in developing policies for a healthy public.

Environmental impact assessment: A mechanism for health and environmental protection

Thailand has institutionalized environmental health impact

assessment (EIA) since 1979, but the follow-up and the monitoring programme were not sufficient for assuring the compliance of the project owners. There has been a continuous improvement in the EIA process since 2003. In 2004, a proposal was submitted to the National Environment Board for improving EIA in eight aspects, namely, the process of analysis, public and community participation, the relationships among the organizations involved, establishment of the EIA fund, the type and size of projects required to have EIA, and the qualification and registration of the individuals and agencies performing EIA, the integration of EIA and the assessment of social impacts in the EIA process.

Part II. Analysis of transitional trend of environmental health in the health promotion perspective
Development of healthy public during the transitional period

The policy on environmental health management was directed towards the control of infectious diseases caused by poor basic sanitation and hygiene. Government sectors, principally the Ministry of Public Health, were "providers" and "managers" of hygienic latrines, clean and safe drinking water, and other basic sanitation measures. Communities were the "receivers". Changes in the public policy process since the beginning of the Fifth National Economic and Social Development Plan were helpful in enabling Thailand to cope with the transition from an agricultural country to an industrializing country. There are three key success factors:

(1) The application of the primary health care concept, followed by the "Health for All by the Year 2000" goal, and implementation of the National Drinking Water Supply and Sanitation Decade.
(2) The application of community participation in public health development.
(3) Effective collaboration of four main ministries responsible for comprehensive rural development led to more effective integration at the local level.

The public policy on environmental

management for health has changed along with the changing contexts. Reformation of the local public administration system throughout the country has laid a foundation to strengthen further the communities and the local authorities so that they can share responsibilities in building the environment for health based upon the communities' needs. Key success factors of these periods are as follows:

(1) Changing the concept of the country's development, which had focused mainly on economic development, to "people-centred development". This resulted in changing the targets and strategies towards environmental development for health, with emphasis on "prevention of health impacts" and "health promotion". In addition, an area-based development strategy facilitated local integration, leading to more success in achieving more comprehensive and holistic development.

(2) Revision and reformation of legislation related to environmental management in 1992 have made law enforcement more effective in environmental management for health. This represented a change in the main concept of the law, not just a revision of the details.

(3) Giving high priority to decentralization of authority to local governments is crucial for the local authorities and communities to effectively share the responsibility to cope with their health and environmental issues.

(4) Application of the healthy cities concept and approaches, and enforcement of the laws that empower the local governments to manage local health and environmental health issues are complementary to each other. It also highlighted the significance of local government, increasing the success of local governments in environmental management for health.

(5) Expression of strong political will by the government with regard to the general public, civil groups, NGOs and governmental organizations through policies

for a healthy public, such as the policy on the elimination of lead additives in petrol and the policy on food safety, among others, contributed to the success of environmental management for health.

The success on community strengthening in environmental management for health

Civil societies have evolved along with the historic development of nations in a sporadic and slow fashion during the early stage of socio-economic development. However, civil societies have undergone rapid development in the past decade, and they are now able to work more productively with government at both the national and local levels.

Key success factors for strengthening of communities' civil groups and networks on health and environmental issues are:

(1) Communities have learned and experienced community strengthening and participation from numerous development projects and programmes, including those involving primary health care, sustainable development, health risk assessment and environment impact assessment. Currently, most projects and programmes related to community development require community participation in order to achieve sustainable results.

(2) Core groups such as intellectual elites, politicians, businessmen, NGOs, and civil groups that have awareness and concerns about health and environmental issues become the starting points that expand later to a larger and wider public.

(3) The general public has experienced and learned from public policy processes conducted by the government, such as in the preparatory process for the National Economic and Social Development Plans, the National Constitution and the Health Act.

Part III. Lessons learned and challenges of creating a supportive environment for health in Thailand

1. By using "quality of life" as the goal of national development, integrated strategy and guidelines were established. They resulted in having more comprehensive health impact management that covered environmental health and socio-economic aspects, all of which are integral parts of health promotion.

2. Strong political commitment, as shown by explicit policy, well-defined targets and effective strategies in environmental management for health promotion, has effectively made the responsible organizations work more efficiently towards achieving targets. Nevertheless, the information and knowledge necessary for policy development and implementation were still lacking owing to the dearth of local databases in both health and environment. The government has been trying very hard to develop the decision-making process in line with the principles of good governance, and it deployed development strategies that allowed the participation of all parties involved, which would lead to the sustainability of development.

3. The proactive participatory decision-making process used in the environmental management system that covered the health, the socio-economic and the environmental aspects was found to be useful not only in preventing adverse health and environmental impacts but also in resolving conflicts of interest. Appropriate tools for proactive environmental management at both the national and local levels were not available and were in great demand for successful environmental management. Some important tools included the legislation that guaranteed citizens' rights to have access to information related to their risks, and to participate in the preparation and approval processes of the environmental impact assessment. Other

important tools were strategic environmental assessment and health impact assessment that required appropriate capacity-building of local authorities and communities so that they would be able to use them effectively.

4. Strengthening of community health and environment networking and the other organizations involved required knowledge-sharing and management processes, as well as technical supports in order to ensure the quality of the health and environmental management system. Appropriate linkages among technical sectors, civil groups and local authorities needed to be established.

5. Local authorities currently have crucial roles to play and various responsibilities in environmental and health promotion and management; their technical and administrative capabilities need to be developed and strengthened to handle the local health and environmental issues effectively. Local policy strengthening is essential for local authorities to manage local problems according to the communities' needs, and thus, the central government should avoid imposing on them the needs of the central government. Local communities also need to work more closely with civil society networks and local technical supportive organizations, using knowledge as a common basis for development.

Part IV. Challenges to the creation of a healthy environment that must be overcome for future health promotion

The challenges to the creation of a healthy environment that must be overcome for future health promotion include the following:

1. The strength of Thailand's political system has resulted from national constitutional challenges, professional administration adhering to the principles of good governance and the involvement of the public and other sectors in monitoring the government with regard to the

healthy public policy process. Capacity-building and the strengthening of civil networks, academia and local authorities, using knowledge-based management, must be accomplished. In addition, capacity-building must also be carried out for achieving friendly cooperation among the public and private sectors.

2. National development focusing on economic development causes impacts on other dimensions of development; hence, the challenges involve how the government will set direction and strategy for national development in order to create balanced socio-economic development and environments.

3. "Healthy Thailand" is therefore an important policy for building a healthy public and it challenges the ability to recruit competency from all sectors to participate actively and continuously in the implementation of the Healthy Thailand policy.

4. The challenge is also to have responsible organizations sincerely carry out proactive measures in developing tools and process for effective impact assessment that would provide a comprehensive impact assessment, and the provision of information on impact assessment for the policy decision-making process to safeguard a supportive environment for health.

5. Ratification of United Nations Conventions and other international agreements does not guarantee full commitment to creating a supportive environment for health. The challenge is to translate the Conventions and the Protocols into action at the national, provincial, local government, community and individual levels. Therefore, the development of skills, and the awareness and participation of the people in the community are challenging endeavours needed to create a supportive environment for health.

TWO DECADES OF TOBACCO-CONSUMPTION CONTROL IN THAILAND: SUCCESS AND CHANGES

Supawongse C.

The World Health Organization (WHO) proclaimed that 31 May every year would be World No-Tobacco Day. In light of that occasion, this article is aimed at taking stock and analysing critical events, achievements and challenges in the attempts to control tobacco consumption in Thailand over the last two decades. A number of recommendations are also proposed to address future challenges. The article is part of the paper which will be presented at the Sixth Global Conference on Health Promotion co-hosted by WHO and the Ministry of Public Health of Thailand.

Background

Cigarette smoking was known among Thai people in the Ayutthaya period (during the 13th -16th centuries), but was not popular until the reign of King Rama V (1868-1910). Nevertheless, tobacco consumption control was carried out haphazardly by each individual group who realized the smoking problem. Until 1986, when the NGO "No-Smoking Campaign Project" was formed under the umbrella of the Folk Doctor Foundation, the activities started more systematically, with greater coordination among agencies, which produced great impacts on health, the economy, society, politics as well as the environment. That year is therefore

regarded as the start of the first decade of tobacco-consumption control in Thailand.

The first decade (1986-1996)

The "No-Smoking Campaign Project" played a pivotal role in advocacy against smoking in the country and it systematically coordinated activities with various organizations.

In late 1987, the Running Event for the "No-Smoking Campaign" was organized by young rural doctors. Six million people throughout the country signed up, demanding protection of non-smokers' rights, and the value of "no-smoking in public areas" emerged and was recognized by the public.

In 1989, the government established the National Committee for the Control of Tobacco Use (NCCTU) to formulate public policy and guidelines for tobacco-consumption control. NCCTU took up the role of drafting the two important pieces of legislation to protect non-smokers' health and to control tobacco products.

During the period 1989-1991, Thailand was forced to open up its market to foreign cigarettes. The United States government threatened to use trade sanctions under Section 301 of the 1974 Trade Act, which prompted a strong campaign against the United States policy by national and international organizations. Although GATT ruled that Thailand had to open up its market to the import of foreign cigarettes, health-related organizations viewed the campaign as a triumph. The ruling accepted the justification of the ban on cigarettes as advocating public health protection. Moreover, the public learned more about the adverse effects of smoking on health, the economy, society and the environment, resulting in much wider support for the no-smoking campaign.

In 1992, the Thai parliament passed two important pieces of legislation to control tobacco products and to protect non-smokers' health. The legislation became instrumental in controlling tobacco consumption,

although enforcement still needs to be improved. In 1993, the Thai government for the first time adopted the policy to increase the excise tax on cigarettes for health reasons, which later greatly affected the control of tobacco consumption among youths.

The second decade (1996-2005)

The decade from 1996 to 2005 has been a period of movements to establish a health promotion organization from "sin taxes". The Health Promotion Foundation Act B.E. 2544 (2001) was, therefore, enacted, resulting in the establishment of the Thai Health Promotion Foundation (ThaiHealth). ThaiHealth started its operations in April 2001, with its annual budget being supplied by the earmarked budget of 2 per cent of the excise taxes on cigarettes and alcoholic beverages. ThaiHealth not only supports projects concerning tobacco and alcohol consumption control, but also encourages all sectors of society to work together on health promotion for all.

During this period, the enforcement of the non-smokers' health protection law was expanded. It required a total ban on smoking in all air-conditioned restaurants, which made Thailand the first country in the world to adopt such a measure to protect non-smokers' rights. In March 2003, the law also required graphic health warning labels to be affixed to cigarette packets, and made Thailand the fourth country to have such a law.

The interference and threats by transnational tobacco corporations continued. There were efforts to privatize the State-owned tobacco industry (the Thai Tobacco Monopoly). However, with the strong campaign against the deal by watchdog organizations, the Cabinet deferred the plan without a due date. On the other hand, owing to the unguarded free trade area agreement (AFTA) of countries in the Association of South East Asian Nations (ASEAN), transnational tobacco corporations took advantage and rapidly expanded their market share from 3 per cent to 15 per cent

of the total. It is also worrying that the Thai government is very keen to conclude free trade agreements with several countries, including the United States. If transnational tobacco corporations can successfully push for the deal, Thai people and the nation will unavoidably face the impacts of deadly tobacco products, including disease, disability, death and great economic losses in the future.

In the international forum, Thailand played a leading role in drafting the WHO Framework Convention on Tobacco Control (WHO FCTC). It signed and ratified the WHO FCTC, which entered into force in 2005. If Thailand can effectively implement its obligations under the treaty and establish an independent monitoring mechanism, it will certainly have positive impacts on tobacco-consumption control within the country.

Process and approaches to critical events

The process of and approaches to tobacco-consumption control in Thailand is in conformity with the concept of a "triangle moving the mountain" proposed by Professor Dr. Prawase Wasi. At each angle of the "triangle" are (1) the application of relevant knowledge, (2) social movements and (3) political support. These three elements are necessary to sort out any difficult issue in society, including tobacco-consumption control. The critical events over the two decades were progressive benchmarks to control tobacco consumption in the Thai society, and the implementation process and approaches to those events attested that success could be attributed to the three elements. However, there is another important factor to the success within the Thai context, i.e., the strong work of Thai NGOs.

The establishment of the "No-Smoking Campaign Project" resulted in active, successive and systematic campaigning activities. It also expanded networks, which started from a group of medical doctors and subsequently included the wider public, including film stars, singers, media reporters and

social critics. The Thailand Health Promotion Institute, which was established in 1994 as an independent academic institution, has played an important role in regularly carrying out studies and developing knowledge and data. It also plays a role in monitoring law enforcement, coordinating with relevant agencies and unveiling the unethical tactics of the transnational tobacco corporations. Dr. Hatai Chitanondh and Professor Dr. Prakit Vathesatogkit, who are leading no-smoking advocates in Thailand with strong and unwavering leadership, have used relevant knowledge, information and social movements throughout the campaign. Both of them devoted their untiring efforts and wisdom to the campaign's success. Furthermore, individuals and organizations involved with the campaign have worked with transparency without any personal profit or vested interest. Consequently, activities were widely and willingly assisted and supported by the public and mass media.

Nevertheless, despite the favourable context, there are also some constraints, such as the following:

- The establishment of NCCTU and its Office under the bureaucratic system
- The obstruction and interference with the work of NGOs by politicians and bureaucrats
- Weaknesses in law enforcement
- The powerful and aggressive advancement of transnational tobacco corporations.

Achievement

It can be said that Thailand is successful in controlling tobacco consumption in a number of areas, which include:

- *A decrease in the prevalence of smoking*
  Tobacco-consumption control over the past two decades prevented 4 million people from smoking, and half of such smokers would be saved from smoking-related diseases.
- *The established value of "no-smoking in public" and*

the rights of non-smokers in society

In the past 10-15 years, smoking was evident everywhere in Thai society. The proximity of smokers and the impacts on the health of the general public were hardly considered. The situation has currently been changed. People are embarrassed to smoke in public places and smoking has become more unacceptable to the public. Consequently, non-smokers' health is better protected within the country, especially when compared with other countries.

- *The establishment of ThaiHealth*

It has been over three years since ThaiHealth started its operations. In 2004 alone, 1,825 million baht or 64.6 percent of its budget was allocated to projects dealing with health risk factors such as alcoholic drinks and tobacco.

Challenges

Currently, tobacco-consumption control in Thailand is facing a number of challenges, as follows:

(1) Thailand has over 10 million smokers, both regular and occasional. The smoking rate among males is 37 per cent, which is still high compared with the rate of 25-29 per cent in developed countries.

(2) Despite good legislation on tobacco-consumption control, the implementation and the enforcement mechanisms still need improvement.

(3) Research and development studies on tobacco-consumption control are still inadequate.

(4) Personnel in the medical and public health fields do not play a sufficiently active role.

(5) The more aggressive are the advancement of and access to the domestic market of transnational tobacco corporations, the more smoking prevalence will increase.

(6) Despite the warning by the World Bank of economic burdens caused by tobacco consumption, the Ministry of Finance often is of the view that the tobacco industry

would enhance economic growth.

Recommendations for the third decade (2005-2015)

With these challenges, the following recommendations are proposed for effective tobacco-consumption control in the third decade (2005-2015):

(1) To develop a national policy and strategic plan, including plan of action, for tobacco-consumption control
(2) To establish a research and development institute for tobacco-consumption control
(3) To establish a mechanism for monitoring law enforcement
(4) To produce a regular report on the implementation of the WHO FCTC, and to establish a national mechanism to monitor Thailand's compliance
(5) To promote and support the role of professional organizations and public health personnel in tobacco-consumption control
(6) To establish a system to act as a watchdog on the advances made by transnational tobacco corporations.

HEALTH PROMOTION: THE CHALLENGE IN THE PREVENTION AND CONTROL OF HIV/AIDS

Sunthrajarn T., Wongkongkathep S., Onnom C., Amornwichet P.

This paper is aimed at describing Thailand's health promotion strategy in the context of the prevention and control of HIV/AIDS. Since the beginning of the HIV epidemic in the early 1990s, Thailand has attained great success in fighting against AIDS. The epidemic reached its peak in 1991, confined among high-risk populations. After the mid-1990s, a reverse epidemic appeared and the HIV situation became endemic. Details of the epidemic and the population profile of HIV/AIDS are provided together with the impact on HIV-infected individuals and their families, behavioural change and national socio-economic development.

Considering the complexity of the impact of HIV/AIDS, the government has strongly emphasized strategic planning in order to guide all agencies and the public in the fight against AIDS. After nearly two decades of AIDS work, the public policy has evolved in three periods. Prior to 1991 was a time of early awareness of the AIDS epidemic, with rapid response by the government in public campaigns, the establishment of sentinel surveillance and the drafting of a national plan. The second period (1991-1997) illustrated the turning point in fighting AIDS, by shifting the direction from public

health to broader community-based action, social mobilization with strong public information. Partnerships with NGOs, community-based groups, people living with HIV/AIDS (PLWHA) and the community were also highlighted. The third period after 1997 started with Thailand's financial crisis which affected AIDS budgets. While progress in AIDS care and treatment rendered hope, NGOs and PLWHA forming local and national networks moved forward to protect their rights to appropriate health care and social justice.

During the evolution of the HIV/AIDS policy, success stories emerged from the strenuous efforts being made in the health sector, other public and private agencies and civic or community groups. Intensive health education, campaigns, public relations on HIV/AIDS and condom use promotion were the early milestones associated with health care service improvement, including AIDS education, sexually-transmitted disease case finding and treatment, voluntary counselling services, and providing medical care and treatment for those with HIV/AIDS. National access to the antiretroviral therapy (ART) programme, namely HAART or triple therapy, was launched nationwide in 2000. With the collaboration of the Global Fund, HAART was offered to 50,752 patients in 2004. A new proposal to cover ART as part of the benefit package under the national health insurance scheme for all Thai citizens is currently under consideration. The prevention of mother-to-child transmission (PMTCT) programme is also a prominent success story in reducing perinatal transmission to 8 per cent in 2002 by obtaining high coverage of antenatal care services and the provision of ART.

Regarding health promotion strategies, the target population approach was considered for PLWHA, pregnant women who were HIV-positive, and the general population. For PLWHA, voluntary counselling and testing has been conducted to promote self-awareness with respect to adequate and clear information, effective dialogue and self-determination. Self-help

groups and community-based care were mostly supported by local NGOs. Interestingly, PLWHA groups and networks have played a major role in advocating human rights protection and social support.

Pregnant women with AIDS, their children and families were regarded as part of the success story in reducing perinatal transmission. The outcome of providing ART, milk powder, blood test follow-up for babies infected with HIV as well as care and treatment for any infected family member reflects the synergy of scientific knowledge, country-based field research and a well-organized health-care delivery system in order to scale up to a national policy and its implementation.

With regard to the general population, there is a need to strengthen family ties in the socio-cultural context in order to support PLWHA and to alleviate their suffering. A number of youth programmes such as life-skills training, "friend corner" counselling and the "To be No.1" self-esteem approach are samples of age-specific interventions concerning sexually related behaviour. To reduce vice and to control drug abuse, social and legal measures were pushed forward, focusing on night entertainment and alcohol consumption.

This paper analyses the key success factors in the overall health promotion approach to HIV/AIDS: strong policies and substantial support by political leaders, adequate funding, a well-organized health service infrastructure with quality assurance, a reliable epidemiological information system, good governance in public management, and experience in the systematic utilization of research and its application to strategic planning.

In the end, recommendations are proposed for facing future challenges. Considerable evidence reveals that the AIDS epidemic is changing, spreading more heterogeneously through socially vulnerable groups and becoming an endemic disease. More target-oriented and culture-sensitive

interventions should be focused upon, and the consistency of public information should be sustained. Appropriate intervention to promote healthy living among PLWHA should be emphasized, including self-care to meet the real demand of those who are suffering. The self-determination capacity of HIV-infected persons, their families and the community should be strengthened. Improvements in the quality of hospital services to protect and better care for ART compliance is essential by providing more staff, more training, close supervision and technical support. Finally, at the policy and strategic levels, how the medical care and health promotion approaches can be integrated and balanced through "societal dynamicity" will require leadership to develop strong partnerships and build social networks to grapple with the new challenges.

ROAD TRAFFIC SAFETY: A LONG JOURNEY IN HEALTH PROMOTION

Aungkasuvapala N., Santikarn C., Chadbunchachai W., Sahamethapat N. and Podhipak P.

Importance of Road traffic injuries and their relationship to health promotion

Road traffic injuries are a major but neglected global public health and development problem. Worldwide, road traffic crashes kill 1.2 million people and injure or disable between 20 million and 50 million people a year. They rank as the eleventh leading cause of death and account for 2.1 per cent of all deaths globally. Without increased effort and new initiatives, road traffic deaths in low and middle-income countries may increase by 80 per cent between 2000 and 2020.

In 2002, 13,354 Thais died from transport crashes. Among these, 855 were young people under 15 years of age, an average of more than 2 people per day, 7 times the number of deaths from dengue haemorrhagic fever in the same year.

Transport and health are closely linked. Appropriate and adequate transport reduces the burden of injuries and air pollution, and increases people's mobility and access to a wide range of services, thus facilitating their choices.

Starting point

- Assessing the problems related to road traffic injuries by existing database systems. If not available, an aggregated system should be established to collect data on the number

of injuries and deaths.

- Road safety requires commitment and informed decision-making by government, industry, non-governmental organizations and international agencies. It also requires participation from many different disciplines, such as road engineers, law enforcement officers and health professionals.
- A lead agency in government should be identified to assess the problems, policies, institutional settings and capacity relating to road safety. That agency should guide the national road safety effort and prepare a national road safety strategy and plan of action.
- There are wide-ranging concerns among authorities, so care must be taken to focus on actions. The greater the focus, the faster the desired outcome can be achieved.

Role of the public health sector

- Road traffic crashes are not traditionally seen as a public health problem, although public health can make a great impact. The World Health Organization has specified important roles to be played by the health sector in its World Report on Road Traffic Injury Prevention, 2004.
- Important roles for the health sector are in epidemiology and information systems, advocacy and research for the promotion of road safety.
- Settings for health offer good opportunities to practice road safety with regard to promotion, a comprehensive approach and an environment supportive of health.
- Successful local initiations can affect national policy.
- Pillars of national activities for the prevention of road traffic injuries are national economic loss estimation, injury surveillance, social mobilization initiation, establishment of infrastructure to secure the coordinating activities and re-orientation of health services.
- Good injury surveillance and

information may not be enough to get policy and enforcement into practice. The public must be intensely and continuously informed through the mass media to create changes in routine practice.

Political action, partnership and strategies for success

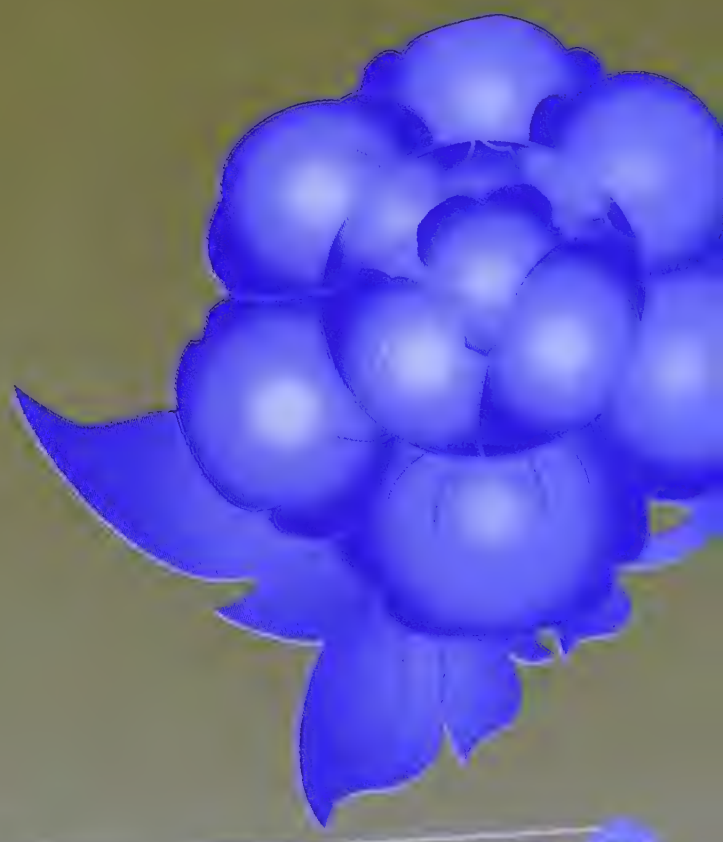
- In 2002, 65 per cent of the patients injured on Thai roads were riding motorcycles. On average, more than one Thai motorcycle rider dies in a transport crash every hour. Among the victims of such crashes are children under 15 years of age. They are admitted to hospital at the rate of one person every hour; approximately 1.5 such crash victims die per day, which is 4 times the number of deaths from dengue haemorrhagic fever. They could be considered byproducts of globalization.
- The daily deaths of motorcyclists do not receive much attention; inequity is an issue in road safety. The media can be the most important partners in making road safety a core responsibility of the government.
- The Five E's strategy of the Thai Road Safety Directing Centre provides a comprehensive approach with focus; it has achieved success through appropriate allocation of financial and human resources, and expanded partnerships.
- The funds from taxes on alcohol and tobacco can play an important role in road safety promotion in developing countries.
- Political leadership, good governance and a reliable technical team are key ingredients to success in promoting traffic safety.
- Creative and steady leadership is even more valuable than money.

More initiatives in the near future

- Testing of motorcycle lanes, the Child Motorcycle Helmet Project, and road safety promoting hospitals are among

the activities aimed at achieving road safety; a safer, cleaner and more accessible mass transportation system in Thailand is also helping to achieve this goal.

- Challenges to the continuing success of road safety promotion are effective working partnerships and the involvement of communities.



EVOLUTION AND DEVELOPMENT CYCLE THAILAND'S HEALTH SYSTEM: FROM "HEALTH FOR ALL" TO "ALL FOR HEALTH"

Phoolcharoen W.

Health systems have consecutively been reformed and developed to keep pace with the "dynamicity" of societal demand, which may be elucidated as an analogy of life's cyclical adjustment of growth and development from its fertilization to the end of life. The reform and development of Thailand's health systems have undergone an evolutionary demand from society throughout the last century. Consequently, people's transitional health improvement has resulted from societal responses rooted in the country's socio-political development as well as being influenced by global bio-medical advances. The alteration of Thailand's health system thus would be examined as a subsystem of the overall political, social and economic evolution.

Life expectancy at birth can be one of the outcome indicators reflecting the extent of population health, which dramatically improved from the 1970s to the 1990s, then gradually increased with the approach of the new millennium. This may have directly resulted from the country's socio-economic development in the last three decades, followed by a reordering of the socio-political configuration at the end of the last millennium.

Life Expectancy at Birth in Thailand (years)

	1974-1976	1995-1996	2000-2005
Males	58.0	69.9	70.2
Females	63.8	74.9	74.7

However, the change in population-to-doctor ratios as a proxy of health manpower - the critical propelling force of the health system - is also responsible for such improvements in health outcomes. The better rate of distribution of doctors in the country seems compatible with the incremental trend in life expectancy at birth.

Population-to-doctor ratios in Bangkok as compared with other regions of Thailand

	1979	1995	2000
Population-to-doctor (PD) ratios in Bangkok	1,210	999	793
PD ratios in Central region compared with Bangkok	9.6	4.1	4.5
PD ratios in Northern region compared with Bangkok	10.8	5.8	5.7
PD ratios in Southern region compared with Bangkok	12.9	5.6	6.5
PD ratios in Northeastern region compared with Bangkok	21.3	10.9	10.5

The first decade of the new millennium is regarded as a cross-roads departing from the former linear development of Thailand's health system towards a transcendent endeavour to leverage challenging accomplishments of system performance and turning towards considering health as each citizen's right. Accordingly, health equity

critically emerged as a mandated mission of health systems. This review of Thailand's health system evolution includes the period from the beginning of the 20th century to the present day (2005), during which time bio-medical and life-science advancements have become intricately interrelated with socio- political evolution as well as playing a critical role in public responses to future confrontations such as hygienic calamities and epidemic diseases.

The reform and development of Thailand's health system may be unfolded in three subsequent stages. From around the 1900s, the first transformation was brought about through the importation of health science and technology. The establishment of the Ministry of Public Health represented a central attempt to extend the modernized health service to all parts of the country. The demarcation of the second stage was the year 1978, which was marked by a political commitment to the Alma-Alta goal of "Health for all by the year 2000". Subsequently, political determination had driven comprehensive health services to every corner of the country, and guaranteed accessibility to health care for the poor. This was followed by the third turning point in 1997, when the regional financial crisis occurred. Also in that year, Thai civil society driven revolutionary constitution was promulgated; it entitles all Thai citizens to a healthy life.

The reform and development of the health system categorized into three eras

	Socio-political Ideology	Health Infrastructure
Before 1977	State's involvement in health development, with restricted sense of individual natural endowment.	Vertical programme with central pool of authority, technology and resources.

The reform and development of the health system categorized into three eras (cont.)

	Socio-political Ideology	Health Infrastructure
1978 - 1996	State's accountability for expansion of health service to cover all citizens.	Comprehensive health service and responsibility to the poor, including rural development.
From 1997	Health as a human right and cross-cutting issue for all development sectors.	Decentralization, devolution and empowerment of health response as mandatory role of broader stakeholders.

Characteristics of the driving force behind the health system in these three eras

	Before 1978	1978 - 1997	Since 1997
Global and state politics	Central governance of public authority, with extension of social service to the provincial level	Economic growth in the midst of political struggle to be more liberalized, with social service expansion to district and village levels	Constitutional reform coincided with financial crisis, raising demand for social safety net and human security

Characteristics of the driving force behind the health system in these three eras (cont.)

	Before 1978	1978 - 1997	Since 1997
Science and technology policy	Technology importation and foreign donors support development of public health and medicine	Progress in country's institutionalization both in terms of education and research	National research and health research have been emphasized as essential tools for competitiveness
Health infrastructure	State's expansion of health services under foreign financial and technical sponsorship	Coverage of provincial and district hospitals with health centers for rural health services	Corporatization of health authority and growing private service and its role in health system
Health resources	Scarcity of human resources, technology and finances donated by foreign and local sources	Supply of health manpower assured by compulsory service and self-reliant budgets and technology	Policy of universal coverage for health care has has mobilized state's resources to cover entire population
Health value and practice	Abolishment of traditional medicine to adopt modern medicine	Primary health care complemented by health volunteers	Health as a human right for all citizens

The achievements of the health system in each phase have contributed to improvement of Thai population health in different aspects. The successful programme in the first phase is reflected in the Malaria Control Programme that has prevented a tremendous number of deaths and the National Family Planning Programme that has reshaped Thailand's demographic structure by reducing fertility to the replacement level. In the second phase, the National AIDS Prevention and Control Programme averted more than 200,000 deaths since 1995 and the Control of Tobacco Consumption has decreased the smoking rate in Thailand from 30 percent in 1976 to be 23.4 percent in 1996. These two programmes have evolved to another level of participation through an initiative involvement by civil society from the beginning.

However, the evolving health system has not keep pace with the acceleration of societal demand at the end of the 20th century. The escalating cost of inefficient health expenditure, health deterioration from unbalanced economic development, and rapid technological advancement with increasing inequity have been obviously detected in the midst of socio-political reform, which calls for broader universal coverage of health care. Thus, since 2000, the Royal Thai Government has marshaled "health system reform" to readjust systematically the health infrastructure so that it is capable of coping with upgraded political demand.

Two main critical movements have been imposed to moderate the change. The primal force has been driven by concerted efforts among civil society, the government sector, academics and the private sector coordinated by the government's organization mandated to draft the "National Health Act" as a new design for the health system. This effort is aimed at clarifying and consolidating societal demand for health as well as reconstructing Thailand's health paradigm and infrastructure for the future. The draft of the law, to which a broad constituency has made contributions through a citizen's

participatory process, is currently in the legislative process.

Then, restructuring of the government's health authority mandated to gear up for the reform has been undertaken. The Health Promotion Fund was established in 2001 to mobilize 2 percent of the tax from the sale of alcohol and tobacco for the health promotion movement. Then, in 2002, the Health Security Office was launched to implement the government's policy of universal health-care coverage. This was followed by the 2003 restructuring of the Ministry of Public Health, which reoriented its role and functions with regard to the new mandates in the evolving health system.

In line with this ongoing reform, innovative roles and functions of the health system were introduced. The health governance system was a key function imposed under the National Health Assembly in the draft National Health Act. Health promotion is a stated government policy as institutionalization of the Thai Health Foundation. Control of health hazards has been integrated as a new function of the Department of Disease Control. The health service system has been reoriented under the government policy of providing universal health coverage or the "30 baht scheme". Consumer health empowerment with regard to food safety has been placed on the national agenda.

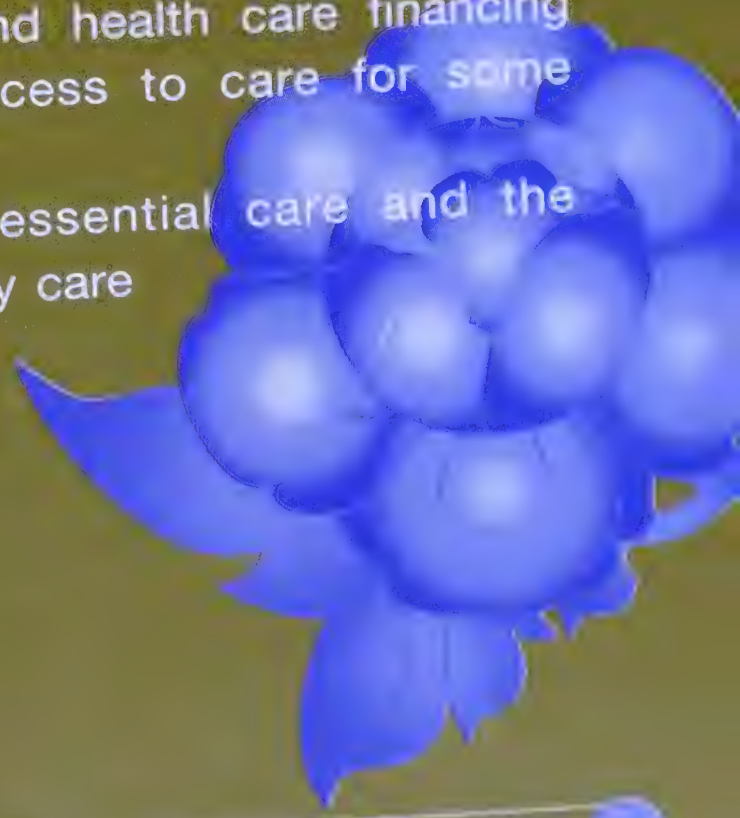
The policies and strategies of the health system in Thailand demonstrate the progress that has been made not only in the control of disease or delivery of health services, but also in the extension of philosophical concern to broader relevant sectors. This affirms a willingness to consider a wider perspective of the country's strategic plan in terms of "human-centred development" that addresses health as a cross-cutting issue in which all sectors participate. These comprise crucial social capital in Thailand's health system.

HEALTH CARE SYSTEM IN THAILAND: REFORMS TOWARDS HEALTH PROMOTION

Nittayaramphong S.,
Jongudomsuk P.

This paper is aimed at reviewing the development of the health care system in Thailand, including analysis and synthesis of experiences learned, and proposing policy recommendations, especially those related to health promotion strategy. The scope of this review is limited only to the system based on Western medicine. Development of the health care system in Thailand will be divided into three eras based on the main characteristics of changes or reforms in the health care system that occurred in each era. These three eras are as follows:

Era 1: (1888-1976)	Reform of the health care system: from traditional to Western medicine
Era 2: (1977-2000)	Primary health care and health care financing reform to improve access to care for some specific populations
Era 3: (2001-present)	Universal access to essential care and the strengthening of primary care



Development of the health care system in each era will be briefly described as follows.

Era 1: Reform of the health care system: from traditional to Western medicine

Western medicine started to strongly influence Thailand's health care system in 1888 with the establishment of Siriraj Hospital and Siriraj Medical School. Since then the health care infrastructure has been expanded continuously although rather slowly at the beginning. It was rapidly expanded nationwide when the country launched the first in its series of five-year National Economic and Social Development Plans. Coverage planning was successfully done by using an administrative area approach. Initially, hospitals were built in Bangkok and were extended to every province. After achieving provincial coverage, the coverage plans for districts and sub-districts were done accordingly using the same approach. By using this approach, public health facilities were decentralized close to people; it was claimed that in 1993 every Thai citizen could access a public health facility within one hour by walking.

The Ministry of Interior was responsible for health and medical care at the beginning but this responsibility was transferred to the Ministry of Public Health (MoPH), which was established in 1942. At the beginning of this era, provision of curative services was split from the provision of preventive and health promotion (P&P) services. Most P&P services were provided through vertical structures owing to the lack of basic health care infrastructure. Integration of health care delivery occurred in the late stage of this era when there was global concern about the integrated approach.

The main successes of health care system development in this era were the increase in geographical coverage of the health care infrastructure and increase of people's acceptance of Western medicine. Despite the emphasis on curative services, disease prevention was the

major concern owing to frequent epidemics. Health was considered as a means for national development by improving economic productivity.

Era 2: Primary health care and financing reform to improve access to care for some specific populations

There were two major changes in the health care system in this era. First, the concept of primary health care (PHC) was adopted and implemented nationwide after the Alma-Ata conference in 1978. Health volunteers were used as the main tool in the PHC strategy. These included village health volunteers (VHV) and village health communicators (VHC). It was expected that one VHC would be placed in every 10 households and one VHV in every village. These trained health volunteers were able to cover about 91 per cent of rural villages in 1986. However, it was found that less than 50 per cent of the health volunteers could succeed in their expected roles and 62 per cent of VHCs became inactive or were lost permanently from the system. In order to strengthen health volunteers, MOPH decided to upgrade all VHCs to VHVs in 1994 and institutionalized VHV by establishing the "National Association of Village Health Volunteers" and providing financial support for its activity. Other initiatives under the PHC strategy including the village drug fund, multi-purpose village fund, Community Primary Health Care Centre (CPHCC) and others, were implemented actively at the beginning but faced problems of sustainability. Despite the limited success of PHC in many areas, implementation of the PHC strategy started changing ways of thought on the role of people in health and raising the importance of first-line health service.

The second major change in this era was the financing reform to improve access to care of some specific populations. In 1975, the Medical Welfare Scheme (MWS) was established to protect the poor. Government employees had been covered by the Civil Servant Medical Benefit Scheme (CSMBS) since 1980 while formal sector employees had been covered by the Social

Security Scheme (SSS) since 1990. MWS and CSMBS were financed by general tax revenues while SSS used tripartite contributions. There were different rationales for different groups of people whom the State tried to protect. The poor were protected because of their inability to pay for their health expenses. Providing medical benefits for the poor could also be considered as an income redistribution measure. Medical benefits were provided to civil servants as a fringe benefit to compensate their relatively low salaries. Medical care is one of the SSS benefits. The scheme was established to serve the growth of the national economy by industrialized sector. Although all these schemes had different benefit packages, provider payments and government budget subsidies, which would affect equity among the schemes, they could cover about 70 per cent of the total population and could improve their access to care.

In summary, the main successes of health care system development in this era included: the changing paradigm in the role of people in health and raising the importance of the first level of the health care system because of the primary health care strategy, increasing the concern of the State about access to care of some specific populations, especially under-privileged groups and the use of financing mechanisms to protect their access to care. Although the importance of primary care was realized with a shift of more investment to the primary care infrastructure, especially at the sub- district and district levels, the quality of care provided by primary care, especially at the health centre level was still less accepted by the people.

Era 3: Universal access to essential care and the strengthening of primary care

The main characteristic of health care system change in this era was the expansion of health care coverage to the uninsured. This was done by merging the existing health financing schemes, MWS and the Health Card Scheme, and expanding them to cover the

uninsured. This new scheme is called the "30 Baht Scheme" or the Universal Coverage Scheme (UCS). All Thai citizens, then, have been covered by three main public health financing schemes. SSS for formal sector employees, CSMBS for government employees and their dependants, and UCS for the rest of the population. UCS is financed by general tax revenues and its budget is allocated on a per capita basis. The three main schemes are still different in benefit packages and provider payments.

UCS tries to use the financing mechanism to strengthen primary care. This is done by requiring primary care as a main contractor, Contracted Unit for Primary Care (CUP), of UCS. Beneficiaries need to register with CUP and the budget will be managed by CUP to ensure access to essential quality services for the beneficiaries. However, owing to the weakness of primary care in Thailand, this limits its success and means that it needs further improvement. In addition, the financing mechanism of P&P services has also been changed by UCS. Management and budget for personal P&P services, which are part of the benefit package of UCS, have been spilt from those for public health services. This could threaten integration of health service delivery and affect the success of health promotion.

It should be noted that the shifting paradigm of health to be a basic right of Thai citizens and the use of the financing mechanism to guarantee this basic right were the main successes of health care system development in this era. The financing mechanism was also used to strengthen primary care. Most P&P services were expected to be delivered comprehensively by the primary care provider. The impact of all health financing measures needs to be monitored and evaluated closely for system adaptation in the future.

Implications for health promotion strategy

Concerning health promotion as a process of enabling people to increase control over, and to

improve, their health, and to reorient health services was considered a means for health promotion action. Experiences from the development of the health care system in Thailand could draw many recommendations for reorientation of the health care system to support health promotion as follows:

1) The health care system should not limit its role to effectively provide only P&P services but should also empower people to take care of their own health. Reorientation of the health care system as well as retraining health personnel are needed to augment this essential role. Primary health care could be considered as a core strategy for this reorientation and the first step is to rethink the roles of people in health and health-service provision.
2) Universal access to P&P services should be guaranteed as a basic right of people because of its positive externality effect and its cost effectiveness. Access to P&P services could affect not only the health of individuals but also the health of people in the community.
3) The health care system needs to be reoriented in order to favour universal access to P&P services. These include the following:
   - Minimizing physical barriers by improving the coverage plan. This could be done by using an administrative area approach or a catchment population approach. The administrative area approach could lead to maldistribution of health facilities if there are different population sizes at the same level of the administrative area; the catchment population approach is preferred in this case.
   - Minimizing financial barriers by using general tax revenues from the central government or local governments. Provider payment for P&P services should be performance-related and an appropriate information system needs to be established to monitor provider performance in

delivering P&P services.

4) Although integration of health service delivery is preferable, a vertical structure still has some roles to play in the provision of P&P services, especially in these circumstances:
   - An emergency situation needs a rapid response;
   - A situation of low prevalence of health problems;
   - Basic health care infrastructure is not operating properly.
5) P&P services are best delivered by a primary care provider. A primary care provider can deliver most health services comprehensively. Its location close to the community also facilitates its interaction with the community and creates mutual understanding and close collaboration between the primary care provider and the community.
6) Health centres and district hospitals are the main public primary care providers in Thailand. The health centre needs to be further strengthened in order to increase acceptability to the people. More investment is needed to improve the capability of health centre personnel as well as the physical infrastructure of the health centre.
7) A private health care provider could participate in the provision of personal P&P services if an appropriate financial incentive is arranged. Involvement of private health care providers in the provision of P&P services could improve service coverage, especially in urban areas, and could shift public investment to other places where the needs are greater.
8) It is rather difficult to empower people by using the bureaucratic structure and the top-down approach. Working with people in a horizontal approach such as a partnership is recommended, and this would facilitate the each other learning process of and also create a sense of ownership.

POVERTY ALLEVIATION AND COMMUNITY STRENGTHENING FOR A HEALTHY PUBLIC POLICY

Phongphit S.

Thailand is counted among the richest countries in the world in terms of natural resources and biological diversity. In fact, it is the world's largest exporter of rice, rubber, cassava and canned pineapple. Paradoxically, however, many of its farmers are still poor; about 10 percent of its population of 62 million is under the "poverty line". Most farmers suffer from debt problems, and they do not know how to find a way out.

To understand "poverty" in the modern sense, we have to go back to the year 1961, when Thailand, advised by the World Bank, launched the first of what would become five-year Economic and Social Development Plans. Industrialization was the main focus. GDP increased at the expense of deterioration of the environment, deforestation and the exploitation of natural resources. Debt problems started, as did migration to urban centres, among other social problems.

The Eighth and Ninth Plans shifted from emphasis on economics to human and community development. Unfortunately, in 1997 Thailand faced one of the most severe financial crisis in its history; it led to painful economic contraction.

The new government, under the leadership of Dr. Thaksin Shinawatra, came up with new policies. There were known as people-centred, with many concrete measures to respond to the needs of people at the grassroots level. Among the measures were debt suspension for three years, universal

health insurance costing Baht 30 per illness, village and urban community fund of Baht 1 million (SMEs). The government also established two important mechanisms to fight illicit drugs and poverty.

In February 2005, Dr. Thaksin Shinawatra was re-elected for a second term. The government of Thaksin 2 subsequently launched several new measures to fight poverty, such as a "community budget" scheme (called SML: Small, Medium, Large Fund for Communities to be used for public purposes as decided by the community itself), SPVs (Special Purpose Vehicles), a mechanism to manage production, processing, marketing and capital resources to reduce risks for farmers and to establish a system to ensure stability in prices and a fair return to farmers; asset capitalization and the transformation of village funds into village banks.

The Thaksin 2 government also launched several other "mega projects" related to poverty eradication, such as projects to solve water problems in rural areas.

As the government is launching such development programmes, a number of communities are also struggling in their own way, mostly with their own means. Common elements of these communities are the goal and the process. The end is "self-reliance"; the process is learning and managing their own resources and community capital, which includes in particular natural resources, knowledge and wisdom, and social capital.

Such communities are proving the opposite of what seems to have been believed by previous governments: the old paradigm that people are "stupid, poor and sick". Communities are proving that they have potential and, with appropriate means, they can express their potential and internal strength.

Such are the cases of Mr. Wiboon Khemchalerm and his communities in the Central Region of the country, the network of Inpeng in the Northeast, the subdistrict of

Mairiang in the South, and several other communities in different parts of the country. All of them represent the new development paradigm. The focus is on the process of learning. For them, to learn and re-manage their life will at the same time win back their self-confidence, as stated by Mr. Wiboon Khemchalerm:

> Forest agriculture brings self-confidence back to oneself. First we must believe that we can depend on ourselves. With this belief, we have freedom of mind. With this freedom, we are not afraid to be rejected; we dare to think, to make decisions and to make choices on how we lead our lives, and finally know better what is right and wrong.

In-peng people, living close to the forest, revitalized the natural resources they once destroyed through cash-crop plantation. They belong to role model communities which survey their own roots, resources and capital in order to reorganize their community life.

Mairiang is a prototype of well-planned community development. The whole process is done by the community itself. This is a learning community. It is proving that a learning community can become more self-reliant, and can solve its problems. Mairiang people make surveys and arrange their own master plan for community development. It has become a knowledge-based community.

Planning a community master plan is a learning process whereby the people in the community search for capital to implement their own economic and social development plan. People learn to identify their life situation, their income, expenditure, debt and resources, as well as their problems and needs. They learn to know themselves and can better identify their real need, and their potential to respond to their need without rushing to find external support as they used to do.

A self-reliant community has the following common characteristics:

1. A learning community
2. A community that can make

decisions independently
3. A community that manages its "capital" efficiently
4. A community with good governance.

A healthy community, according to the communities concerned, has the following elements:

1. Food stability
2. Occupational stability
3. Integrated knowledge (local knowledge and wisdom with external knowledge)
4. Modern medical treatment

According to such communities, the indicators of a healthy community are:

1. To produce enough food to meet its needs all year round; to produce food free from chemical substances; and to produce food for its own consumption.
2. To reduce expenses in all aspects, to increase income; and reduce debts.
3. To reduce the use of chemical substances in agricultural production and therefore reduce the consumption of chemical substances oneself.
4. To learn to take care of one's health by applying indigenous knowledge; to use herbs and natural healing methods rather than to go to health centres or hospitals; to reduce the purchase of medicine or reimbursement of allowances for health care from their Savings Group.
5. To help each other more; to have less stress; and to come together for discussion on problems.
6. To reduce their regular health problems and chronic illnesses.
7. To reduce the intake of liquor, cigarettes, monosodium glutamate (MSG) (a food additive), carbonated beverages and snacks, all of which are considered to be the causes of ill-health.

It seems that the government's development policies and th community's approach have diverse and contrasting characters. Whereas the government's schemes still emphasize "projects" and "financial" aspects, the communities focus on

the learning process, with self-reliance as the goal. However, if there must be a meeting point and a common ground on which to collaborate, the "sufficiency economy", advocated by His Majesty the King, could be the case.

> Sufficiency economy means having enough, to be reasonable and necessary to have an "immune system" against any adverse effect from change either from outside or from within.

To be a "tiger" is not important. It is important to have enough to survive. Having enough to survive means self-sufficiency. I have said before that self-sufficiency does not mean that each family must produce its own food, weave and sew its own clothes. This is going too far. Each village or district must have relative self-sufficiency. Things that are produced in surplus can be sold, but should be sold in the same region, not too far so that the transportation cost is minimized. (From His Majesty the King's royal speech on 4 December 1997).

A sufficiency economy does not mean stepping backward into the past, but rather stepping back so that one can gather oneself, rethink and gain confidence before moving forward to implement things with more confidence and stability. It does not mean that one has to do everything all by oneself.

"In order to fulfill the concept of self-sufficiency", according to His Majesty in the same speech, a person "does not have to implement all, not even half of it; it is enough to implement only one fourth, to live".

His Majesty the King foresaw that implementation of a sufficiency economy was not simple and has given a warning that:

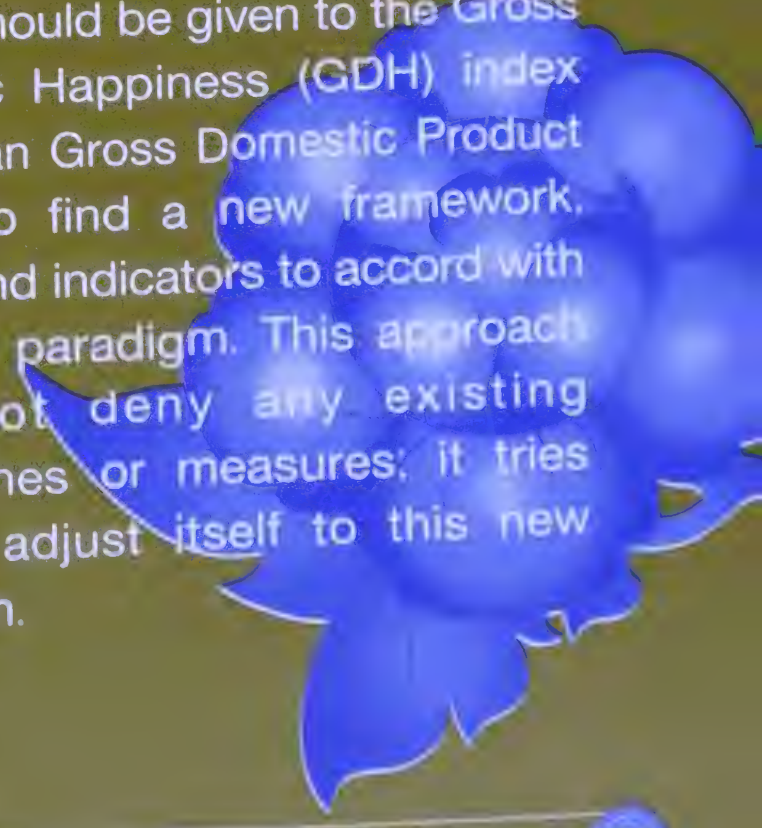
> All these require knowledge, thoroughness and care in applying academic knowledge to planning and implementation at each stage. At the same time

we need to create a strong foundation for people in the nation, especially government officials, theorists and businessmen at all levels to have virtue, integrity, honesty and appropriate knowledge, in order to lead life with endurance, efforts and wisdom to create balance and to be ready to face change from outside which comes abruptly and broadly in all fields, whether they are material, societal, environmental or cultural" (His Majesty the King's speech on 4 December 1997).

In order to find a meeting point, the following are proposals to the Government:

1. The sufficiency economy principle should be used as a mechanism to assess the result and conclude the lessons learned from the First to the Seventh National Plans and from the Eight to the Ninth National Plans.
2. To develop along the approach taken at the beginning of the Thaksin 1 Administration, or an "inward looking" approach in which priority is given to development within the country first. The paradigm must be re-adjusted at all levels, to make self-reliance the target for the family, the community and the country; to create an integrated development plan which links the community master plan with that of the province's District Administration Organization and that of the government.
3. To use the new framework to adjust and manage people-centred projects already announced by the government, so that they are all interrelated.

Priority should be given to the Gross Domestic Happiness (GDH) index rather than Gross Domestic Product (GDP), to find a new framework, criteria and indicators to accord with this new paradigm. This approach does not deny any existing approaches or measures; it tries only to adjust itself to this new paradigm.



All this should be linked to the Millennium Development Goals, the first of which is "Eradicating extreme poverty and hunger", with the last goal considered as a "cross-cutting issue" linking all eight goals together. This last goal is "Develop a global partnership for development".

In this same spirit, and with a holistic view and integrated vision, we can similarly consider the third strategy of health promotion as referred to in the Ottawa Charter: Community Strengthening.

THE ROLE OF THAI TRADITIONAL MEDICINE IN HEALTH PROMOTION

Chokevivat V.,
Chuthaputti A.

The Kingdom of Thailand has its own system of traditional medicine called "Thai traditional medicine" (TTM). It originated during the Sukhothai period (1238-1377) and progressively developed as a means of national health care during the Ayutthaya (1350-1767) until the early Rattanakosin (1782-1916) periods. During the reign of King Rama V (1868-1910), Siriraj Hospital, Thailand's first Western-style hospital and medical school, was officially opened in 1888. Initially, both TTM and modern medical services were provided. The medical school that taught both disciplines of medicine was established in 1889. However, in 1916 the teaching of TTM and the TTM service at Siriraj Hospital were discontinued because the two principles were considered incompatible and confusing to the medical students. The abandonment of the systematic teaching of TTM in the medical school marked the beginning of the decline in the acceptance of TTM by the public and TTM therefore became only a branch of non-conventional medicine in Thailand.

The revival of Thai traditional medicine

The revival of the TTM began around 1978 after the proclamation of the Alma-Ata Declaration, urging member countries in the World Health Organization (WHO) to use primary health care (PHC) programs to achieve the goal of "Health for All by the Year 2000". As a result, Thailand's Ministry of Public Health responded to that call by promoting the use of medicinal plants in PHC

since the Fourth Health Development Plan (1977-1981). The government's policy on the promotion of the use medicinal plants and TTM in the country's health care system has continued until today as stated in the Fifth to the Ninth Health Development Plans (1982-2006).

"In 1989, the Ministry established the "Collaborating Centre for the Development of Thai Traditional Medicine and Pharmacy" to play an active role in the revival of TTM. This Centre was later upgraded to the division level in 1993 as the "Institute of Thai Traditional Medicine" (ITTM). In October 2002, as a result of the Bureaucratic Reform Act, the "Department for Development of Thai Traditional and Alternative Medicine" (DTAM) was established as a new department under the Ministry and ITTM became an institute under DTAM.

Reasons for the government's revival of Thai traditional medicine

The main reasons why the Thai government reconsidered the value of TTM and decided to revive TTM and integrate it into the national health system could be summarized as follows: -

1. The World Health Organization and national policy on traditional medicine and primary health care (PHC), as previously mentioned.
2. The loss of self-reliance concerning domestic resources for health promotion and the loss of control over national health expenditure as the country relied more on high-priced modern medicine for health care.
3. The limitations of modern medicine, i.e., serious side effects of certain drugs, their high cost and their inability to cure several lifestyle-related diseases, opened the way for traditional medicine to serve as an alternative choice.
4. Problems with the quality of the health care system of TTM. After over 60 years of neglect, the overall quality of TTM service was seriously in need of improvement in order to conserve national wisdom and

enhance consumer protection.

5. The potential of Thai herbal products and TTM practice for the country's economy. The global expansion of the botanical dietary supplement market during the past 10 years has given Thailand an opportunity to export its products abroad. Moreover, the recent boom in the spa business has created job opportunities for Thai people to work as massage therapists at home and abroad.
6. The success of China and India concerning the integration of traditional medicine in their health systems serves as a good example for others to follow.

The role of Thai traditional medicine in health promotion

TTM is regarded as traditional wisdom, a body of knowledge and mode of practice to care for the health of the Thai people congruent with the Thai way of life and based on the principles of Buddhism. According to TTM, the human body is composed of four elements, namely, earth, water, wind and fire. When an imbalance in these internal or external elements occurs, a person will become ill. For health promotion, TTM uses various forms of traditional practices to complement each other, i.e., medical therapy, pharmacy, massage, midwifery and maternal and child health care, Buddhist rites and meditation, and other rituals.

Various aspects and practices of TTM that have been promoted for health promotion and/or integrated into the health service are as follows:

Medicinal plants and traditional medicines

Thai massage or nuad thai

Hot herbal compresses and herbal steam baths

The practice of dhammanamai which is composed of:

4.1 Kayanamai (healthy body), i.e.

- Eating right according to the principles of TTM

- Exercise, e.g., ruesi-dud-ton, or Thai traditional stretch exercise

4.2 Jitanamai (healthy mind), i.e., practice of meditation

4.3 Chevitanamai (healthy lifestyle), i.e., live one's life in the "Middle Path" of Buddhism, or other religious belief.

1. Medicinal plants and traditional medicines and health promotion

The public sector, private sector, NGOs and international agencies have all become involved in promoting the use of medicinal plants or herbal medicines for health promotion by:

- Promoting the use of selected medicinal plants in PHC for the treatment and relief of 19 groups of common minor symptoms.
- During the period 1986-1988, GTZ supported complete-cycle research on five medicinal plants in PHC to obtain scientific evidence to support their use.
- Selecting three traditional preparations and scientifically developing single herbal preparations from five herbs and including them on the National List of Essential Drugs to promote their use in public health settings.
- Increasing easy public access to herbal medicinal products by naming 27 traditional preparations as traditional household remedies (THR) that may be sold without licence, and issuing a list of crude drugs that can be used as ingredients in 25 groups of THR.
- Some public hospitals manufacture herbal medicines and sell them to the public by collaborating with medicinal plant growers.

2. Thai massage or nuad thai

Thai traditional massage or nuad thai is a branch of TTM and a form of manual therapy that is useful for health promotion or relaxation and can also effectively cure or relieve several musculoskeletal symptoms and diseases. Thai massage is divided into two categories: folk massage and royal massage. Both are based on the principle of *sen sib* or 10 *(sib)* primary energy lines *(sen)*, and were developed, refined

and passed on from generation to generation over the years. The Ministry of Public Health through ITTM developed four main massage curricula for the general public that are now adopted by many certified schools or institutes:

1. Curriculum on foot massage for health (60 hours)
2. Curriculum on Thai traditional massage for health or relaxation (folk massage - 150 hours)
3. Thai traditional massage curriculum (royal massage - 372 hours)
4. Thai traditional massage curriculum (royal massage - 800 hours)

ITTM has continuously promoted Thai massage among the public by providing training, making teaching aids and distributing them to public health service facilities and TTM Health Promotion Centres throughout the country so that massage-training courses can be offered to the public nationwide.

Currently, Thai massage is becoming popular and well known worldwide as some world-class spas and resorts now offer Thai massage. With the concern of consumer safety in mind, DTAM together with the Department of Labour have therefore set up standards for Thai massage based on the curricula of the Ministry, namely:

Level I - Thai massage for health and relaxation (150-hour curriculum)
Level II - Thai massage for relieving symptoms (372-hour curriculum)
Level III - Thai massage for therapeutic purposes (800-hour curriculum)

The second and the third curricula involve the study of "Thai therapeutic massage". Persons who finish these courses will be able to treat about 10 and 35 symptoms and diseases respectively.

3. Hot herbal compresses and herbal steam baths

Hot herbal compresses have been used to relieve muscle sprain, muscular and joint pain and discomfort. The herbal compress called *luk pra kob* is a blend of herbs, including plai rhizome, turmeric,

lemongrass, kaffir-lime peel, with salt, camphor and borneol camphor wrapped in cotton cloth. Steamed *luk pra kob* applied to affected areas of the body helps to increase regional blood flow and the active substances released from the herbs exert anti-inflammatory action on the inflamed and aching muscles. Research has shown that *luk pra kob* can relieve myofascial pain and knee osteoarthritis.

An herbal steam bath boils a herbal combination similar to that used in herbal compresses in a steam room or a closed chamber. It can be used for therapeutic or health promotion purposes and was originally used for postpartum care. A herbal steam bath helps to stimulate the circulatory and respiratory systems, relieve stress and muscle tension, nourish the skin, and foster excretion of body waste.

Both the hot herbal compress and herbal steam bath are now TTM services that are provided in many public health service facilities and are commonly found on the Thai spa service menu to improve general health, rid the body of toxins and improve blood circulation. *Luk pra kob* is also well received by foreigners and is therefore an important export item under the category of herbal products.

4. Practice of *Dhammanamai*

Dhammanamai is the application of Buddhist teachings in TTM for holistic health care of the body, the mind, the society and the environment. The practice of *dhammanamai* corresponds with the principles of health promotion, as it enables people to increase control over the determinants of health and thereby to improve their health in order to achieve a state of complete physical, mental and social well-being. *Dhammanamai* can be divided into three areas of practice, namely, kayanamai, jitanamai and chevitanamai.

4.1 Kayanamai (healthy body)
According to TTM, the human body starts to deteriorate after a person reaches the age of 32. Therefore, in order to stay healthy for as long as possible and prevent diseases,

people need to take care of their body by exercise and eating right.

4.1.1 Ruesi dud ton, or Thai traditional stretch exercise

Ruesi dud ton is Thai traditional stretch exercise combining breathing exercise and meditation by focusing on breathing rhythm; hence, it is good for the body and mind of people of all ages. It can be used for health promotion, disease prevention, rehabilitation of some minor disorders, and to help increase body agility and muscle coordination, stimulate blood circulation and promote good concentration.

ITTM selected 15 out of 127 postures of *ruesi dud ton* that cover the exercise of all body parts suitable for all age groups to be promoted for health promotion. To educate the public about *ruesi dud ton*, ITTM published booklets and made videos and CDs that can be used for training and self-study.

4.1.2 Eat right according to TTM

Based on the principles of TTM, changes in the weather and the external elements during different seasons can adversely affect the balance of the body elements and health. Medicinal plants, vegetables and fruits with different tastes possess different health benefits and affect the body elements differently and therefore are suitable for people with different tard chao reun (dominant basic element). Our Thai ancestors integrated the knowledge of TTM into daily life, using food and drink to balance the basic elements of the body when there has been a change in the weather, and to keep the body healthy.

4.2 *Jitanamai* (healthy mind)

Jitanamai is the training and strengthening of one's mind so that one will be able to focus and concentrate better by practicing meditation, studying and following Buddhist teachings or other religious belief based on one's faith, which will eventually help to sharpen one's mind and intellect. In addition, jitanamai also includes saying prayers, behaving well towards others and extending love and kindness to others, which are a part

of the religious practices of all faiths.

4.3 *Chevitanamai* (healthy life)
Chevitanamai is to lead one's life by following the "Middle Path" of Buddhist teachings and to earn one's living doing a good and honest job, taking care of our home and environment in a good, clean and healthful manner, which will eventually lead to a peaceful mind and healthy life.

5. TTM services in the public health service facilities

To promote the use of TTM for health promotion, it is necessary to provide the public with easy access to TTM services by integrating such services in the public health service facilities and disseminating TTM knowledge to the public.

All levels of hospitals or health service centres of the Ministry of Public Health that provide TTM services can be divided into four levels based on the types of services:

- Level 1 - Those that sell single herbal medicines only.
- Level 2 - Those that sell herbal medicines AND provide TTM services, e.g., Thai massage, hot herbal compress and herbal steam bath.
- Level 3 - Those that provide level 2 services AND provide TTM training.
- Level 4 - Those that provide level 3 services AND produce herbal medicines.

According to an ITTM survey in 2003, the numbers of regional/ general hospitals, community hospitals, and health centres that provide any level of TTM services were 83.3 per cent (80/96), 67.9 per cent (492/726) and 22.4 per cent (2,169/9,683), respectively.

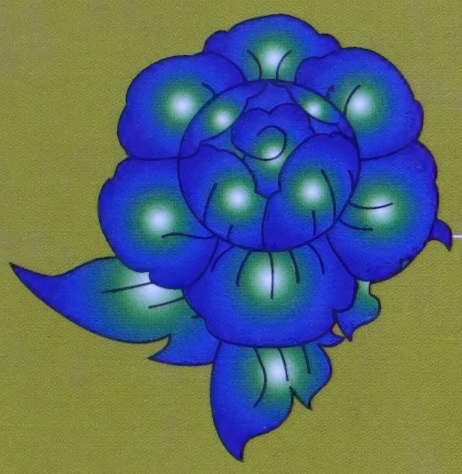
6. Lessons learned and suggestions

The success of the revival and the integration of TTM into the health service system and the promotion of TTM practice for health promotion of the Thai people could be a result of the following:

1. Government policy and financial support are the main driving forces that have brought

TTM services to the public and helped to increase the awareness of Thai people about the role TTM can play in health promotion. In addition, the fact that public hospitals manufacture, use and sell herbal medicines as well as provide TTM services and training for the public helps to build the confidence in and demand for TTM and herbal medicines among the Thai people.

2. Social mobilization and strengthening community action. The "Back-to-Nature" and "health conscious" trends that have florished all over the world since the 1990s have partly contributed to the welcoming and acceptance of TTM as a means of health care and health promotion in Thailand. The establishment of offices like ITTM and DTAM to play an active role in formulating policy and implementing plans by collaborating with other health-care facilities and communities to create awareness and participation also contributes to the successful promotion and integration of traditional medicine in the health-care system. Community action will eventually result in public acceptance and participation in the use of traditional medicine as a part of health promotion and health care nationwide.
3. Empowering people with evidence-based TTM. As traditional medicine has not been scientifically proved, it may require pre-clinical and clinical research to establish the quality, safety and efficacy of traditional medicines or some therapeutic methods in order to gain acceptance from the public and the medical community and for consumer protection. Strong evidence-based traditional medicine through clinical research will empower people with regard to its application for health promotion and successful integration into the mainstream health-care system.



POLICY AND PARTNERSHIP FOR ACTION: ADDRESSING THE DETERMINANTS OF H

6th Global Conference on Health Promotion (6GCHP)
7-11 August 2005 Bangkok, Thailand